CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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REVIEW AND EVALUATION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. Federal regulations at 42 CFR §§ 455-456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services.

This chapter provides information on utilization review and control requirements handled by the Department of Medical Assistance Services (DMAS).

REVIEW AND EVALUATION OVERVIEW

DMAS routinely conducts utilization review to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Providers and recipients are identified for review either from systems-generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Some provider reviews are initiated on a regular basis to meet federal requirements. DMAS reviews claims for services provided by or resulting from referrals by authorized primary care providers (PCPs) in managed care and utilization control programs. In some programs, random sampling may be used to determine areas for on-site reviews. There are also computerized exception reports which look at utilization patterns for providers and recipients. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. An individual exception profile report is generated for each recipient and provider who exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary. Statistical sampling may be used in a review.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS may use a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the number and amount of invalid dollars paid in the audit sample is compared to the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients.

Utilization Review Visits

Medical records of recipients currently receiving psychiatric services, as well as a sample of closed medical records, may be reviewed. DMAS may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, utilization review on-site visits, or desk reviews will be made to each psychiatric provider, to review medical records and conduct an overall review of the provision of services with respect to all of the following:

- Comprehensive care being provided;
- Adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each recipient for the scope of services offered;
- Medical necessity of the continued services;
- Feasibility of meeting the recipient’s psychiatric needs as an alternate level of care; and
- Verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, the utilization review analyst(s) will meet with staff

members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings of the analyst(s) during the utilization review. Based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Upon completion of a desk review, DMAS will respond to the provider in writing and cite any federal or state regulations that were not followed. In addition, a letter outlining any retractions necessary as a result of not following federal or state regulations will be sent to the provider.

If DMAS requests corrective action plans, the mental health clinic provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 692-0480
FAX: (804) 786-0414

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits or fraud and abuse by non-providers are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card-sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-0156
FAX: (804) 786-6229

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid recipients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) in the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and pharmacy in the client Medical Management program (CMM). (See "Exhibits" at the end of Chapter I for detailed information on the CMM Program.) If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 78-6548
CMM Helpline: 1-888-323-0589
FAX: (804) 786-5799

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.